Information Systems and Continuing Education

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THE PURPOSE OF CONTINUING EDUCATION is to aid the physician in maintaining or improving his level of professional competence so he may give high quality care to his patients in the hospital or his office. His individual needs should determine the method and content of his program of education. Diagnosis of his educational needs requires an analysis of his clinical performance.

Systems for evaluation of a physician's work in the hospital through medical staff committee reviews and automated record summaries, such as Professional Activities Study and Medical Audit Program, are well developed in accredited hospitals.[1] However, these are not fully utilized for assisting the physician to maintain or improve his level of competence. Indeed, they have yet to encompass the largest part of the physician's work—that conducted in his office. In the future, with the development of closer organizational ties between office and hospital, as seen in hospital-based practice, and with the growth of information systems that link office with hospital, a more useful spectrum of the physician's work is expected to come under scrutiny of the medical staff review programs, since records of office practice will be integrated with those of the hospital. A medical communication system designed by Bell System to link medical care facilities through a computer illustrates one approach to unifying hospital and office records. The physician's office records kept by the computer could be combined with those of his hospital patients to form a complete file of his patient care services that would be accessible to medical staff review.

Most hospitals currently carry out only a limited quality evaluation through traditional committee functions such as tissue review, utilization review and medical records review. All of these audit functions could be consolidated into a broader medical audit activity to form a better basis for judgment about quality of care. A medical audit of broader scope would use established methods of retrospective case analysis and evaluation, collection and analysis of epidemiologic data, and observation of current medical care as it is rendered. Through a broadly conceived review activity, the medical staff can gain a sound basis for judgment of individual physicians' practices as well as an overall view of the quality of medical care services in the hospital. Such information may be easily translated into a statement of educational needs.

To do this the community hospital staff must link up the broad medical audit with a system of education. The staff can develop and organize its own teaching potential with the assistance of the education consultant in cooperative programs with education institutions. Then, having capability to provide teaching, and with intimate knowledge of the practice of the individual physician, the medical staff committee is prepared to provide an education prescription for the physician and to judge its effectiveness.

Approaches to developing an education program based on this model—a program that is community-based, individualized and linked to an evaluation of medical practice—is illustrated in part by a cooperative program now being carried on between Pacific Medical Center, San Francisco, and community hospitals for improvement of skills in

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intensive care practice.[2] Working with the medical staff in the hospital, the education consultant aids in the identification of needs, organization for education activities, and implementation of appropriate teaching. Complementing and supporting programs such as this, our continuing study of education practices aims to define and refine the basic tools of effective continuing education. Focusing on methods of program design and evaluation, faculty development and organization for individualized teaching, we seek new ways to make teaching relevant and effective.

Teaching methods available in the community hospital include case consultation, supervision of patient care or procedures, presentation and discussion of cases by the practitioner, full-time preceptorship programs and the design and conduct of individual reading programs. None of these are new methods, but we hope to apply them to the new purposes and with new connections to the essential feedback from medical audit activities. The individual is emphasized in design and evaluation of continuing education. Early experience suggests that the benefits of individual-directed teaching and tutorial approaches far exceed those of lecture or conference teaching for a given investment of resources.

To develop the capability to appraise and improve the quality of care in a community hospital requires not only these techniques of education but full acceptance and participation by all medical staff members. The true physician must be both teacher and student and meet the Hippocratic imperative to "impart precept, oral instruction, and all other learning" to fellow physicians.

REFERENCES

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2. Pacific Medical Center: Training of physicians in skills of intensive care as applicable in small general hospitals, unpublished description of a pilot program under California Regional Medical Program, Area 1, 1968.